



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Lake Pointe Medical Center

Respondent Name

Sentry Insurance a Mutual Co

MFDR Tracking Number

M4-15-1207-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 18, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "My client has reviewed the bill and confirmed that the services are properly coded and should be paid immediately. The Hospital is an inpatient acute care hospital, not a rehabilitation hospital or a physical therapy clinic which my utilize G Codes. As such, the hospital does not and will not bill the claims as if it is a PT provider. Further, the patient never received PT services. There was merely and evaluation of the patient post surgery, not physical therapy (PT) or some reimbursement methodology derived from a G code."

Amount in Dispute: \$27,972.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider billed code 97001, which requires the Medicare G codes and modifiers to pay. We have informed the provider that this is the information needed to complete the claim and have a clean claim. They have not responded with a corrected billing. We are following the specific guideline attached for billing requirements. Texas has a Zero Tolerance policy and we are unable to add codes to complete the claim for payment. If a single invalid procedure code or modifier is incorrect or not reported correctly, we cannot change the bill."

Response Submitted by: Sentry Insurance

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2014	Outpatient Hospital Services	\$27,972.50	\$8,342.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing

- 18 – Duplicate claim/service
- 193 – Original payment decision is being maintained

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 29823 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of \$4,259.01. This amount multiplied by 60% yields an unadjusted labor-related amount of \$2,555.41. This amount multiplied by the annual wage index for this facility of 0.9657 yields an adjusted labor-related amount of \$2,467.76. The non-labor related portion is 40% of the APC rate or \$1,703.60. The sum of the labor and non-labor related amounts is \$4,171.36. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.149. This ratio multiplied by the billed charge of \$11,434.45 yields a cost of \$1,703.73. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$4,171.36 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$2,440.03. The allocated portion of packaged costs is \$2,440.03. This amount added to the service cost yields a total cost of \$4,143.76. The cost of these services exceeds the annual fixed-dollar threshold of \$2,900. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total Medicare facility specific reimbursement amount for this line is \$4,171.36. This amount multiplied by 200% yields a MAR of \$8,342.72.
 - Per Medicare Claims Processing Manual Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services. D. "Providers and Practitioners Affected. The functional reporting requirements apply to the therapy services furnished by the following providers: hospitals, CAHs, SNFs, CORFs, rehabilitation agencies, and HHAs (when the beneficiary is not under a home health plan of care). It applies to the following practitioners: physical therapists, occupational therapists, and speech-language pathologists in private practice (TPPs), physicians, and NPPs as noted above. The term "clinician" is applied to these practitioners throughout this manual section. G Required Reporting of Functional G-codes and Severity Modifiers. The functional G-codes and severity modifiers listed above are used in the required reporting on therapy claims at certain specified points during therapy episodes of care. Claims containing these functional G-codes must also contain another billable and separately payable (non-bundled) service. Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC). Functional reporting using the G-codes and corresponding severity modifiers is required reporting on specified therapy claims. Specifically, they are required on claims:

- When an evaluative procedure, including a re-evaluative one, (HCPCS/CPT codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004) is furnished and billed;

28 Texas Administrative Code §134.203(b) states in pertinent part, “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided...” Based on the above this line from the claim does not meet the requirements of Rule 134.203(b). Separate payment is not recommended.

- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2710 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2795 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J7050 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
3. The total allowable reimbursement for the services in dispute is \$8,342.72. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$8,342.72. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$8,342.72.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$8,342.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February , 2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.